

ATTACHMENT E
Applicant with Physical Disabilities

Name of Applicant: _____

Name of Licensed Physician: _____

Date Completed: _____

1. In what capacity do you know the applicant?

2.

How long have you known or worked with the applicant?

3. When did you last see the applicant? _____

4.

What is the formal diagnosis of the applicants' disability? _____

5. What was the date of onset?

6. What is the prognosis? _____

7.

How does the applicants' disability/health condition affect daily life activities?

8. Please define reasonable expectations for each skill (reasonable walking distances, reasonable terrain that can be negotiated, reasonable time that applicant could stand and wait for a bus, etc.).

Required Travel Skills	Reasonable Expectations
Walking distance to/from stops.	
Stepping on/off curbs and crossing streets.	
Negotiating hills/steep terrain.	
Standing time at bus stop.	
Boarding lift and non-lift buses.	
Other:	

9. Please define in more detail any environmental issues that may apply (temperature sensitivities – what temperatures would present unsafe or risky conditions for the applicant).

Environmental Issues	Unsafe/Risky Conditions
Extreme heat/humidity.	
Extreme cold.	
Poor air quality.	
Other:	

Please list the type, frequency, dose, and any comments about how the medication(s) may complicate the individual's independent mobility (travel) in the community.

Medication Type	Dosage	Effect on Functional Ability (if any)

PLACE LICENSE PHYSICIAN OFFICIAL STAMP BELOW:

Signature: _____ Date: _____

Print Name and Title: _____

Current Guam Medical License No.: _____

Business Address: _____

Mailing Address: _____

Telephone No.: _____ Fax: _____